Policy Research

WORKING PAPERS

Population, Health, and Nutrition

Population and Human Resources
Department
The World Bank
October 1991
WPS 797

# Using Field Visits to Improve the Quality of Family Planning, Health, and Nutrition Programs

## A Supervisor's Manual

Richard Heaver

A manual to help supervising staff find out what is really happening in the field, in a way that supports health workers and focuses on improving the quality of service to the poor.

Policy Research

WORKING PAPERS

Population, Health, and Nutrition

WPS 797

This paper is a joint product of the Population, Health, and Nutrition Division, Population and Human Resources Department and the Population and Human Resources Division, Technical Department, Asia Regional Office. Copies are available free from the World Bank, 1818 H Street NW, Washington DC 20433. Please contact Otilia Nadora, room S6-065, extension 31091 (20 pages). October 1991.

Most health professionals who have worked in rural areas have had the experience of being supervised badly: the flying visit by a superior who inspects the records, delivers a critical speech, and disappears without ever finding out what is really going on in the health center area. Such visits seem designed more to demonstrate the supervisor's authority than to help the field worker to serve local people better.

This manual is designed to help field supervisors supervise in a way that deepens insights into local situations, supports health workers, and focuses on improving the quality of service to the poor.

The checklist of questions is not intended to be definitive or rigidly applied. Depending on the needs of a given program, some areas may need to be probed more deeply, and others shortened or omitted altogether.

Heaver provides guidelines for planning (a first visit and subsequent) visits to a program area; for visiting villages and talking with mothers; for visiting health care workers; for visiting nutrition workers; and for using findings to make changes in program design or implementation, to reorient the way supervision is done, and to change worker behavior. He also provides a sample field visit report.



Produced by the Policy Research Dissemination Center

CONTENTS

# USING FIELD VISITS TO IMPROVE FAMILY PLANNING, HEALTH AND NUTRITION PROGRAM QUALITY

## A SUPERVISOR'S MANUAL

## I. INTRODUCTION

Most health professionals who have worked in rural areas have had the experience of being supervised badly: the flying visit by a superior who inspects the records, delivers a critical speech, and disappears without ever finding out what is really going on in the health center area. Such visits seem more designed to demonstrate the supervisor's authority than to help the field worker to better serve local people.

Yet field visits provide an important opportunity to improve program quality--if they are properly planned, if supervisors spend enough time talking to the right people, and if the right questions are asked in the right manner. They provide an opportunity not only to find out what is happening at the periphery and take corrective action, but also to improve the process of supervision through demonstrating how to go about it in a non-inspectional, supportive way.

This paper is an attempt to pull together field experience in supervision in the form of a manual. It is primarily aimed at helping aid agency staff supervise in a way which deepens insight into local situations, is supportive of health workers, and is focussed on improving the quality of service to the poor. It may also be useful to health sector managers in developing countries who are interested in reorienting their own process of supervision.

It should be emphasized that the checklists of questions given below are not intended to be definitive or to be rigidly applied. Depending on the needs of a given program, some areas may need to be probed more deeply, while others can be shortened or omitted altogether.

## II. PLANNING THE VISIT

Most unproductive field visits go wrong before the supervisor steps into his jeep, because they have been inadequately planned. Time spent before the trip on setting it up right is a good investment. This section suggests some do's and don'ts for planning field visits.

The First Visit To A Program Area

If you want to see the poorest people, they likely will not live near the state or district capital. Specify who you want to see, or you may be taken to nearer, better off areas, and to the health facilities which are shown to all visiting dignitaries.

Make sure you set aside enough time. If you have less than 1-2 full days in the field net of driving time, the trip probably isn't worth doing.

Agree with those planning the trip how many facilities you will visit. As a general guide, you should not plan to visit more than two facilities in a half day (even if the driving distances between them are short), if you want the time to find out what is happening in them. You need to allow at least two hours net of driving time for a visit to a village and its health post. If you don't specify what you want, you may get a whistle-stop tour of six or eight facilities or villages in a day, with half the time spent in the car.

Question the trip planners about the performance ratings of the facilities to be visited. Are they in the top third, middle third, or bottom third of the league? If they are planning to show you the best, try to get a more even distribution.

Agree on the balance you want between time spent in higher level facilities, health posts, and villages. Try and arrange it so that you visit health posts and villages early in the day, higher level facilities later; then, if the schedule is delayed, you won't miss out on the crucial inter-face between service providers and clients.

Try to ensure that the key program decision-makers travel with you. This has three benefits. It gets senior staff away from their files and gives them a taste of field reality. It will give you time to get to know them on a personal level, and build up the trust needed to work together. And most important, the shared view of program problems and constraints--based on what you see, not statistics or reports--is the best foundation for reaching consensus on changes in program strategy.

But try and ensure that the cavalcade of cars and accompanying staff is limited. It is impossible to interview field workers and mothers successfully if they are intimidated by large numbers of government officials standing in the background.

Ascertain if your hosts plan any ceremony attached to the visit. If they would like you to open a new health center, politely refuse if you can; this sets the tone that this is a working visit, not a political tour.

Subsequent Visits

Hopefully, the time spent with senior program managers during a first visit will help develop a shared understanding about the approach to supervision. It should then be possible to ask, for subsequent visits, if the following can be arranged.

1. Surprise visits to health facilities. The ideal is to drive to the district capital, look at a district map, and choose on the spot the facilities you will visit that day. This minimizes the chances that the facilities will have been specially staffed, stocked with drugs, or even repainted for your visit. Whether this is possible will depend on whether your counterpart has confidence after your first visit that it is safe to show you the program's problems, because you genuinely want to work with him to improve things rather than show him up.

2. No official receptions, garlands or speeches. These may be essential during the first visit, for the host to demonstrate that he is honoring his guest. A quiet word from the program manager can usually ensure that subsequent visits are low key, without giving offence.

3. Meeting with local politicians last, not first. On your first visit, you will probably have to call on local politicians on your arrival, for reasons of protocol. They often keep you waiting, so that your whole schedule is disrupted. It should be possible to arrange that on subsequent visits you will see them last, on the grounds that the meeting will be more productive if you can talk about what you have seen. This also helps to send the message that local politicians have a substantive not just ceremonial role vis-a-vis local health services.

4. Reduce the cavalcade to two cars. Ideally, you should be able to reduce your escort to one car from head-quarters, carrying you and the key program decision-makers; and one car from the district, with staff who know the place you are going to.

## III. VISITING VILLAGES

The typical supervisor spends most or all of his field visit time in health centers talking to health staff, rather than in villages talking to local people. Yet the only way to find out whether outreach is taking place, whether health education is working, and what the clients' views are of the local health services, is to talk not to service providers but consumers. If the focus of your project or program is on outreach and preventive care, probably two thirds of field visit time should be spent talking to mothers, and only one third talking to health workers.

A common argument used by field trip organizers against the idea of surprise visits to health centers is that the worker may be absent, on tour in an outlying village. This does not matter. By asking the kinds of questions

outlined below, a fairly good picture can be built up of health service performance whether or not the worker is present.

On Arrival

Courtesy call. On arrival, you will probably be asked to meet the village headman. This courtesy call can be made useful with the following kinds of questions.

1. What are the main occupations of the people in your village? What do the best off people do? What do the worst off people do? Have things been getting better or worse over the last few years? Who has done better? Who did less well? Where do the poorer people live in the village? (It can be useful, and can help break the ice, for you and the headman to sketch a map of the village together.)

2. What do you see as the main health and nutrition problems in your village? Do you see any difference between now and a few years ago?

3. Who are the providers of health care in the village, modern and traditional? Who do the people like best? Do you have any personal contact with the health service? What kind? What are the problems with the health services? If more money could be made available for services in your village, how would you like to see it spent?

Where to go and who to talk to. You now know who the poor people are and where they live. If your time is short, head for that part of the village, because it is especially important to know if the health worker visits there regularly. Try to avoid the headman accompanying you, since he may intimidate your interviewees. One way of doing this politely is to ask if you may go round alone, but then come back at the end of the visit to tell him about what you saw.

When you get there, let the health worker choose the first house you visit. This will be a house the worker visits regularly, and may be untypical. But this will let you see the best part of her work, and will make her feel more comfortable. After this first visit, you should choose the houses you visit, and the people you talk to.

In some cultures and with some interviewees, it is possible to walk up to a house, be invited in, and be in an open and frank discussion in ten minutes. In others, home visits will be seen as intrusive, or the arrival of a higher status outsider in the home may lead to an attack of nerves. In such cases, you may do better to stop in a public place used by women, such as the well, and start chatting to people there. Mothers may be less shy in a group where they can support each other, and in the open air rather than enclosed surroundings.

Try and talk to mothers who have children with them. Then you can talk about the health of the children in front of you. This helps to personalize the talk, and is more comfortable for the mother--she can pay

attention to the children as she talks, rather than feeling fixed by your steely gaze.

Translation. Spending a little time organizing this is very important. If the local dialect is different from what is spoken in the capital, have one of the local health workers act as translator; even if local people understand the national language, they may be uncomfortable and less open speaking in it. But if the local language is the same as the national language, have the program director from the central ministry do the translating, providing you feel he will not lose face. Getting him to ask the questions will involve him in the process like nothing else. (By day two, an initially status-conscious program manager is often so interested in what's happening that he wants to take over the questions anyway.)

Try to ensure that exactly what you say is translated. Usually, translators will at some point rephrase your questions, add questions of their own, or try to influence the interviewee's response. Even if you don't understand the language, you can usually pick this up because the translated questions will become longer than your originals, and the answers you get will not be to exactly the question you asked.

Try to ensure that exactly what the interviewee says is translated. Usually, some embroidery or opinions of the translator will get added, or he may simply tell you not the interviewee's answer, but what he thinks you need to hear. You can usually sense, in the same way, that this is happening.

## Talking To Mothers

Throughout this section, the word mother should be taken to include mothers-in-law and grandmothers as well, since these are equally important influencers of maternal and child health. Try to talk to some men as well, but in many cultures they will be out at work.

Every time you move to a new mother or group of women, remember to have the translator explain what you are doing in the village. Have him say that you are there to find out about the health problems in the village, and whether any help can be provided to improve things. Don't let people feel you are there to check health service performance--although you are--or they will clam up. They have to live with the health worker whose performance you are asking them to criticize.

The questions given below, and throughout this manual, are illustrative rather than complete. Note the order of questions. Questions about the family and its health status are asked first. This establishes your concern about the interviewee. Questions about possibly sensitive topics, such as family planning or worker effectiveness, are toward the end, when hopefully rapport will have been built up.

Don't carry an outline with you of questions you want to ask, and don't take notes. This applies to interviews with both clients and service providers. They will not speak freely if you have a clipboard in front of

you. After each visit, take a little time in the car to write up some notes while things are fresh in your mind.

Social and Health Status. Do you come from this village? Have you lived here a long time?

2. Do you have some other work apart from working in the house? What does your husband do? (Knowing this, and looking at their house and dress, you know the income level without asking.)

3. How many children do you have? What are their ages? (You have already discovered something about probable family planning use.)

4. Have you had any particular health problems in your family recently? When was that? How bad was it? What did you do about it? (n.b. you can often see health problems, such as scabies or PEM, in the children in front of you; note whether these are identified by the mother.)

5. When you or your children are ill and you can't cure it at home, who do you go to? (If both traditional and modern practitioners are used, find out why, and who is used for what kind of illness.)

Child care. Have your children had any problems with diarrhea? (A good one to start with--almost everyone has had.) How long did it last? Was it severe? What did you do about it? Do you feed your children differently when they have diarrhea? (If she knows about rehydration, find out if she knows how to make home mixture, and the quantity and frequency of giving this.)

2. Have any of your children had fever recently? How bad was it? What did you do about it? Do you feed your children differently when they have fever? (Find out whether she can recognize a severe ARI and knows to call the health worker.)

3. Have your children been immunized? What for? When, and who by? Have they had their Vitamin A supplement?

4. How do you feel about your children's diet? Are you able to give them everything that you want them to eat? What do they normally eat on a typical day? Do you feed them differently from other family members? (Find out if she knows the importance of green vegetables.)

5. When you had your last child, did you have enough breast-milk for him? Did you give him anything other than breast-milk in the first six months? How long did you continue breast-feeding? How old was he when you started to give solid food? What did you give him, and how much?

6. When your last child was just born, how soon after did you first feed him, and what did you give him?

Maternal care. When you were going to have your last baby, did you get any particular advice from the health worker? Do you remember how far along with your pregnancy you were when you talked with her?

2. Did you eat more, or less, or the same, while you were pregnant? Did you eat new kinds of food, or stop eating some foods?

3. Did you take any iron pills while you were pregnant? When did you start? How often did you take them?

4. Where did you go to have the baby? Who helped you give birth? Did you or the birth attendant have any special kit? What were the things you needed to be careful about when you had the baby?

Family plannning. Would you like to have another baby? If no, what can be done? What do you think is the ideal number of children? What does your husband think?

2. If another baby is planned, how soon are you planning? If a delay is preferred, what can be done to ensure this? What do you think is the best gap between babies? What does your husband think?

3. Are many people in the village using family planning these days? What are the methods which are the most popular, and why? Do younger and older women seem to prefer different methods?

4. (If the mother is prepared to say whether she is contracepting and what she is using.) How did you know about this method? What made you choose it? (If advised by a health worker.) What other methods did she tell you about? What did she say about their advantages and disadvantages?

Effectiveness of outreach. Is there a health worker who looks after this village? What is her name? Has she ever visited you at home? Have you ever visited her in her clinic?

2. When was the last time she visited your house? And when was the time before that? (n.b. questions about specific events will get more reliable answers than 'how often does she come'?)

3. The last time she came to your house, how long did she stay talking with you? What did you talk about? Did she give you any particular advice? Did you ask her any particular questions?

4. Have you ever met with the supervisor of your health worker? When was that, and what happened at that meeting?

## IV. VISITING HEALTH WORKERS

### On Arrival

If there are several of you in your review team, split up, and have the others go visit another health center in the local area, or go talk to the villagers while you are talking to the health worker. Health workers will not talk to you openly if they have a large audience, especially if there are senior staff in it.

Launching straight into a face to face interview can be nerve-wracking for the health worker, who may feel interrogated. It is often best to start the visit by asking her to show you around her clinic and quarters. This takes the spotlight off her and helps to break the ice. It also gives you the opportunity to ask her whether the design of the facility suits her needs, and whether it is being kept properly maintained for her. This kind of interest signals you care about her, and have probably not come to find fault.

This initial tour will probably also tell you two things. By the look of the place, you can usually see whether it has been done up for your arrival. And by the amount and kinds of personal effects in the health worker's quarters, you should be able to tell whether she is actually living there. This is important information. Workers who are actually living in the local town and not their quarters cannot be doing effective outreach, because much of their day is spent commuting from local town to the health center.

As you go round the clinic, glance at the visitors book. If it's full of names from the capital or abroad, you have been had. This is the show-piece center they bring all distinguished visitors to. Don't spend too long.

Note that the following questions cover most topics of importance other than the inspection of registers. This is because most supervisors concentrate on this already, thus sending the signal that it is record-keeping, and not outreach and preventive care, which is really important.

### Talking To Health Workers

Once again, the order of questions is important. It is useful to start with questions about the local area, because these are legitimate; the worker knows she knows about this and you don't. Do not start with questions about her technical knowledge, or she will feel that you have come to test her, and will be ill at ease. Only ask general questions about what problems she has toward the end of the interview, when rapport has been established; earlier on, she may feel obliged to tell you that everything is fine, or give you a stock complaint, such as the inadequacy of the drug supply.

Local knowledge. How long have you been the health worker in this area? (If she is a newcomer, you can keep the interview short.)

2. How many people are there in your health center area? What do you see as the main health problems? (Compare this with your knowledge of the actual epidemiology.) Are there groups of particularly poor people in your area? What do they do for a living? Do they seem to have different health problems from other people?

3. If there isn't already one, ask her to do a sketch of her health center area, showing the main villages and hamlets. How do you travel to the villages? How long does it take you to get to each village? Which are the hard to reach areas? Do the poorer people live in particular areas?

4. Do you know how many 0-3 year children there are in your area? (There should be about 70-90 per thousand population in Asia, 100-120 in Africa.) Do you know how many pregnant women there currently are in your area? (There should be about 20-30 per thousand population in Asia, about 40 in Africa. These are important questions; they show whether she is aware of the her key target population. For example, if she thinks, as is common, that there are about ten pregnant women, then you know already that ante-natal care is not effective in this area.)

5. Do you know of any deaths in your area in the last year? What were they due to?

Work routines. In general, it is better to ask specific questions about what the worker did on a specific day; if you ask general questions about what she normally does, you are more likely to hear what she is supposed to do than what she actually does.

1. Do you have a regular work routine for each week or each month? How do you divide up your time between working in the clinic, going out in the villages, going for meetings, and keeping up your records?

2. When was the last day you spent in the villages? Let's think back to that day, and talk about it, so I can understand better how health workers here plan their work. How did you decide which village to visit? And when you got there, how did you decide which families to visit?

3. On that particular day, how long did you stay in the village? How many houses did you visit? How long did you stay in each house? What did you talk about? Was there any group meeting with mothers?

4. Did you assist with any deliveries in the past six months? How many? Where did they take place? Were there any complications?

Technical knowledge. In general, it is better to ask questions about particular cases she has recently had, than to ask general questions about whether she knows a particular thing. The former comes across as you familiarizing yourself with her area and her views, the latter as a test.

1. Have you had any child diarrhea cases recently? What did you advise the mother? Supposing the diarrhea is persistent--what then?

2. Have you had any child fever cases recently? What did you tell the mother? (Find out if she knows when ARI can be home treated, when it needs the anti-biotic she has at her level, and when it needs referral to a higher level.)

3. Out of the pregnant women in your area in the last year, have you had any with obstetric complications? What are the signs you use to identify if a woman is likely to have this kind of problem?

4. Have you seen any low birth-weight baby in your area recently? What advice did you give the mother about this baby?

5. What contraceptive do you advise women to take? If a woman is interested in a temporary method, which methods do you feel are suitable for which types of people? Think back to the last time you recommended orals to someone--what advice did you give her?

Health education practices. What are the main wrong health and nutrition practices you see in this area? Has the health service, or you personally, targeted any particular practices as ones to try and change as a priority? How are you going about that?

2. What are the different types of IEC methods in use in this area? Which do you find the most effective? Why is that?

3. Are there any particular groups in the area who are specially resistant to practices you want to promote? Who are they and what are the practices? Is anything special being done about this? (Key question, to know if she understands about segmenting her market, and developing different strategies to meet different needs.)

4. Are there some mothers in the area who are particularly highly motivated about health and nutrition? Who are they? Are they doing anything differently to care for their chilren? Do you use them to help you in any way?

5. Are there any women's groups in your area? Do you use them in any way to help your work?

6. Are there any other workers from other government or non-government organizations in your area? Do you work with them, and if so how?

Training. How long ago was it you had your pre-service training? Thinking back on it, which were the things you found most useful for your work? What would you have liked to spend more time on?

2. Have you had any in-service training? When and where was that, and who was doing the teaching? How long was the course? How much was in the classroom, how much in a clinic or hospital, and how much in a village? Do you feel the need for in-service training again this year? What would you like to be taught about?

3. Thinking back to the last training session, what were the most useful topics to your work? What would you have liked to spend more time on? How many hours or days were spent on technical things? How many on health education? How did they teach you health education? (Role-playing for interpersonal IEC?) Did they teach you about planning your work routines?

Supervisory support. Who do you report to in the local health service? When did you last have a visit from that person? And when was the time before that? Last time he or she came, how long did he/she stay? What did you talk about? Did he give you any special training or advice? Did you raise any particular problems?

2. Do you have staff meetings at the local health center? How often? How long was the last one? Could you describe what happened at it? (Was it just inspection of registers, or was there training? Was there interchange of experience among para-medicals? Was there group problem-solving?)

3. Apart from your immediate supervisor, does anyone else give you any support here? (Does the local doctor take an interest? Has the local health education specialist been to visit?)

Miscellaneous. Are there ORS packets in the center? Cotrimoxazole? (or the local drug of choice for ARIs.) Vitamin A? Iron? (Note the expiry dates, and whether damp or heat has got to the drugs/supplements.) Is there a blood pressure gauge? Equipment for sterilizing syringes? A child weighing scale? Do they work?

2. When was the last time your drug supply was replenished? (If it was last week, this was probably in your honor.) And when was the time before that? Which medicines do you find you use up first and run out of? Which do you use up slowest, and have to spare? When was the last time you ran out of one--or all--drugs? How long were you without it/them?

3. Do you have any particular problems in doing your work well? (With a nervous worker, who will automatically say no, this should be rephrased to: If there was anything we could do to help you do your work better, what would you like?)

## V. VISITING NUTRITION WORKERS

In some programs, the health worker is responsible for nutrition work; in others a separate worker looks after growth monitoring, growth charting, case management, and supplementary feeding where this is given. If these tasks are part of your program, the following questions and routines may be useful. Questions on nutrition education given above are not repeated here.

Knowledge of the local situation. How many people are living in your nutrition center area? Do you know how many of these are children under three? (the age most nutritionally at risk; there should be 70-90 per thousand population in Asia, 100-120 per thousand in Africa.)

2. What is the normal diet of the people in your area? Does it change at different times of year? Do the poorer people eat differently from the better off people? What work do the poorer people do here? Do they work harder at particular times of year? Do they have less money at particular times of year?

3. Is there a malnutrition problem in your area? How can you know how bad it is? Which kinds of people are malnourished? Is it all the year round or seasonal? How has the nutrition situation changed over the last five years?

4. Do you know how many under threes are severely malnourished in your area? Moderately malnourished? How do you measure this? Do you know how many pregnant women are malnourished? How do you measure this?

5. Apart from people not having enough to eat, are there any other malnutrition problems in your area? Do you know how many children have vitamin A deficiency? How do you measure it? Do you know how many pregnant women have anaemia? How do you measure it? (mild, moderate, severe?) Why are these deficiencies a problem?

6. Do you know how many babies were born in your area in the last year? Do you know how many of them weighed less than then they should at birth? How do you define low birth weight here? How do you measure it, and who does the weighing?

Coverage. How many under threes have had their six-monthly vitamin A supplement? (where a mega-dose is given). How many pregnant women are currently receiving iron? (From these figures you can work out approximate coverage figures for these interventions.)

2. How many under threes were weighed/arm-banded by you in each of the last three months? (Go through the records and check the overall numbers. Look also at the weighing regularity for a sample of children; is it the same limited group of children being weighed regularly or a larger group being weighed irregularly? If much less than 80% of the under threes are being weighed/arm-banded, you have a problem; there could be significant malnutrition in the area which is not being detected.)

3. When and where do you do your growth monitoring? If it is on particular days of the month, how do you let mothers know? Do mothers help you bring the mothers together, or with the actual weighing/banding? If some mothers don't come when you are weighing, how do you get their children weighed?

4. How many pregnant women are there in your area at the moment? In your program, do you check whether they are putting on weight as they

should? How do you do that? How many of them are not doing as well as they should?

Case management. Ask the worker to pick out the growth charts for all the children with severe malnutrition. Note whether these children are being monitored regularly. Spend some time asking about each child; you must be sure whether the worker knows each child and its family well. These are the children most likely to die.

1. Why do you think that this child has moved down into grade three? Has it had any illnesses? Do you know how many brothers and sisters the child has? Are they malnourished too? Is this the first or last child in the family, or what?

2. How far away does this child's family live? How many income-earners are in the family? Are they regularly employed, and what do they do? Are there any particular problems in the family?

3. Does the mother bring the child regularly for weighing? Does she have a copy of the child's growth chart? What nutrition advice have you given her? Does she follow it?

4. Does the child come for supplementary feeding? If not, why not? (Does the mother take the child to work with her?) If yes, who brings the child? Does the child seem to like the food? Can the child finish the food? If not, what do you do about that?

5. Has the local health worker seen this child? What did she have to say about her? (In the case of a persistently severely malnourished child). Has the child been taken to see a doctor? Do you know what his diagnosis was? Do you know if it was the local health center doctor, or a specialist child doctor?

6. If you have time, ask to be taken to the house of one of the severely malnourished children. Talk to the mother about the causes of her child's problem, and what she is doing about it.

Supplementary feeding. How many mothers are receiving supplementary feeding (SF) in your area? How many children? Can we go through your records and see the nutrition status of these children? (Check to see whether there are malnourished children who are not being fed; or whether significant numbers of children who are not malnourished are being fed.)

2. Have you had any breaks in the supply of your SF in the past year? Does it arrive in good condition? Where do you store it? Does it last without going bad?

3. What is your system for deciding which mothers or children will get SF? Are they eligible immediately they fall into malnutrition/fail to gain weight, or after some weeks of observation? What advice do you give to mothers whose children need SF?

4. Do you serve the same food every day, or different recipes? Do the children like it? Do you serve different food for the mothers? Do they like it? Do you serve different food for children who are very young, and for severely malnourished children? Do they have any problems in eating or finishing the food? (Try to be present at a feeding time, because many workers will automatically say they have no problems in these areas.)

5. Where do the children and the mothers eat the food? Do you allow them to take the food home with them if they want to? If not, why not? If they do take home, do you see any problems with that? If there is take home, do you find that the malnourished children share the food with others in the family? Do you think that the food you give is fed by the mothers in addition to the food they would normally prepare, or do you think that the food you give means that the mothers don't have to make so much of their own food for their children?

6. Supposing a child who was malnourished has regained weight. Do you stop giving him the supplement? Immediately, or after some time? Do you find that some of the children who graduate from feeding get malnourished again and come back into feeding? Do you have any records on how often this happens? Do you notice anything in common about these children or their families?

Quality of growth monitoring. Check that the worker has both child and adult scales. Ask the worker to weigh and chart a small child, preferably one that looks undernourished. See whether a) she checks that the scale is zeroed before weighing; b) she is noting the exact weight or is rounding off and hence inaccurate; c) she can correctly enter the weight on the chart; and d) she can correctly identify the nutrition status of the child.

Take some time to look through the growth charts at the center. See if they have been regularly kept up--or are too regular. Signs that they were filled in yesterday in honor of your visit include unusually clean charts; clustering of the weights around particular figures; unusually neat lines all filled in with the same pen or pencil; and monthly weight gains that are improbably large.

Pick out some typical types of charts to see whether the worker knows how to use them for nutrition education. These might include a) charts dipping slowly into malnutrition between six months and a year--does the worker recognize that this is probably a weaning problem?; b) charts dipping very sharply into malnutrition in a particular month--does she recognize that this was probably a diarrhea or measles episode?; c) a comparison of two charts where the children are the the same weight for age, but one child is tracking steadily just below the top of grade two, and the other has recently moved down into grade two and is still in decline--can she differentiate stunting from nutritional decline? In each case ask the worker what advice she would give the child's mother.

If the worker is knowledgeable on the above, ask her to pull out the growth charts for the some of the children of the mothers who by now will have gathered around the center. See if the mothers a) know the nutrition

status of their child, b) know how it has been changing over the last few months, c) can read the growth chart, and d) can remember any advice that the worker has given them.

## V. MAKING USE OF THE PROCESS

The approach to field supervision illustrated above can be useful in improving program quality in two distinct ways: use of the findings to make design or implementation changes to the program; and use of the process to reorient the way supervision is done and to change worker behavior.

### Using The Findings

Are the findings valid? The systematic routines and questions summarized above are aimed at gaining as clear an understanding of what is happening in the field as is possible from brief visits. Clearly they cannot substitute, in terms of depth of insight, for the findings of longer term participant observation studies in villages and health centers. But equally, such studies cannot be carried out on a routine basis over large areas.

Despite the inevitable limitations of brief visits, experience in several sectors with using structured interviewing as a rapid rural appraisal technique suggests that the insights gained are often more valid than those from large scale questionnaire surveys, which may be the only practical alternative. Such surveys may be based on statistically valid samples, but are not open-ended enough to fully explore program quality. They are also expensive and quickly out-dated.

The validity issue for this kind of field supervision is therefore not so much whether it reflects reasonably well what is going on in a given local area, as whether the local area you are visiting really reflects the successes and constraints of the program you are reviewing in general. Do not therefore pay too much attention to the findings of an individual field visit. Make field visits to several areas which you think should show differences in client knowledge or attitudes, in worker motivation, in health resource availability or in local managerial capacity, and only then begin to draw general conclusions. Cross-check the validity of the opinions you are forming with people knowledgeable about the area--especially experienced local health managers, and field researchers in the social sectors who may have worked in the area.

Applying the findings. It is important not to use your interview findings to correct the behavior of workers on the spot. This is a common and tempting practice; most supervisors cannot resist demonstrating they know better, or showing their authority. But guiding the individual worker is the job of the worker's immediate supervisor, not yours. Correcting workers on the spot has three undesirable consequences. It may undermine your image as open-minded inquirer rather than inspector. It may undermine the authority of the worker's immediate supervisor. Most important, if you correct the health

worker in front of others, it will undermine the local respect for her which is essential for her effectiveness. The only exception to this rule is if the worker is doing something dangerous, such as not sterilizing syringes properly in an AIDS-endemic area. Then you must ensure that she is taken aside by one of the local supervisors and quietly corrected immediately.

Your findings about constraints and problems should be used at two distinct levels. Where the problem appears to be a local one and not generic to the program, it should be discussed at the end of the day with local health service managers, and they should be asked to suggest a solution for it.

More important for you, as a supervisor from the foreign aid agency or national capital, is to focus on those problems which are systemic in the program. There is no point in correcting an individual worker when some bad practice is widespread, because the problem lies not with her but with the training system which has ill-equipped her, or the MIS and supervision system which is sending her the wrong kinds of signals. Nor do most regional health service managers, given the centralized nature of most public health programs, have the power to correct these problems themselves.

Therefore, systemic problems need to be addressed at the center or state level through redesign of aspects of the program's software, after discussion with regional and central health service managers. But use the opportunity of your field visit to ask health workers and supervisors about possible solutions to systemic problems; they often know what needs to be done, even if they can't do it.

An example of the way in which an aide-memoire might be drafted to focus on systemic problems found during field supervision visits is given in the annex to this paper.

Using The Process

Most supervisors focus on finding out what is going wrong and correcting things on the spot, at the expense of using the supervison process to improve program quality. The process can be used in at least three positive ways.

Giving positive feedback. Most supervisors focus and comment in their field visits on what is going wrong. Instead, focus on what is wrong and store it away for future analysis; but comment on what is going right. Praise the worker and her supervisor where they are doing well. This not only improves health service morale and performance. It sends important signals to your counterparts that you are on their side and not just a fault-finder.

What you spend time on. Workers and their supervisors will note very quickly what you are spending time on. If you and the health service managers with you spend most of your supervision visit looking at health center records, you can bet that is what will workers will focus on before the next visit. If on the other hand, your time is spent in the village asking about outreach and the feelings of local people about the health service, this sends important signals to workers about what is important to management.

Workers do not respond to health policies or written guidelines; they respond to what they think their bosses think is important.

Demonstrating how to supervise. Therefore, as important as what you find out from your visit is the demonstration effect of how you go about your visit. This is why it is important to have one or more senior program managers with you while you visit, because good supervision cannot be taught as easily as it can be picked up from observation. At the beginning, it may not be obvious to program managers why you are doing the things that you do and asking the questions you ask in the order and way you are. But they will quickly and usually enthusiastically catch on, and during the second and third days of a field trip can be encouraged to take over some of the interviewing.

Once this point has been reached, you can usefully focus an evening discussion with your colleagues on the purposes of supervision, and how supervision can be managed to improve service quality. If the general approach to supervision you are demonstrating finds favor, discuss how it can be institutionalized in the health system. It is doubtful whether this can be done solely through in-service training courses, in view of the importance to learning of accompanying a good supervisor in the field and watching.

Institutionalizing the process is therefore best done by senior managers themselves visiting the field regularly and reorienting their immediate subordinates; who in turn will take their immediate subordinates on field visits and orient them. A senior manager might aim to make such a trip once in two months; a middle manager once a month.

The perceived costs of moving to such a system will be great. Managers will be taken away from their files, and will be unavailable to their political masters for several days at a time; they will be away from their families; and the travel may be uncomfortable. But the benefits are potentially tremendous, in terms of direct exposure to and real learning from the field; and in terms of demonstration and motivational effect on staff down the line.

ANNEX

## SAMPLE FIELD VISIT REPORT

### Areas Visited

This four day trip was to X and Y districts. District X is a tribal district with scattered settlements and hilly terrain, 100 miles from the state capital; the population lives mainly through collecting forest produce. District Y is an agricultural district with a relatively dense population, surrounding a large market town. Infant mortality and contraceptive prevalence rates appear to be similar in both districts to the state average. In each district, two referral centers and four villages and their related health posts were visited.

### Findings: Health Service Performance

With two exceptions (see below), service performance was quite similar in the two locations despite the differences in local conditions. This probably reflects the institutionalization of in-service training programs for field workers during the last three years of the project.

Health. Immunization, ORS and FP programs are going well. In the case of immunization, an important factor in the high coverage rates appears to be the efforts made by community nutrition workers to prepare local people and gather mothers in advance of the monthly arrival of the immunization team. Mothers appear not only to be aware of ORS, but make routine use of home fluids for rehydration; this change from awareness to practice is new within the last two years, and reflects the success of communication campaigns. Problems were identified in four main areas:

(i) District X, although better off overall, has a less economically homogenous population than district Y. It appears that outreach visits in district X are less frequent than average to landless labourer groups who live in segregated hamlets outside the main villages, and whose health and nutritional status are particularly poor.

(ii) Although contraceptive prevalence rates are satisfactory, there is a heavy bias toward sterilization. This appears to be because workers are not counselling mothers on the availability of the full range of temporary methods of contraception. While mothers are aware of the other methods, they do not seem to understand their advantages and disadvantages.

(iii) Mothers are receiving very limited counselling from health (as opposed to community nutrition workers) in the area of nutrition. Mothers appear not to be increasing their food intake during pregnancy. The relatively higher status and respect given to health workers, and the near universal coverage now of ante-natal care visits, gives them an important opportunity to influence mothers' nutrition behavior which is being missed.

Nutrition. The workers met were able to accurately weigh and chart children, and the mothers of children being routinely charted appeared to understand the purpose of the chart, and knew the progress of their children. This is a major step forward from the situation of two years ago, and probably reflects the emphasis in the recent round of in-service training on hands-on training, including role-playing, in this area. Two significant problems were identified.

(i) Although the quality of weighing and growth charting are high, a quick comparison of numbers of growth charts and the estimated child population in the local area suggests that the percentage of children being weighed monthly is no higher than 60%. This is a very serious problem, because a significant number of cases of moderate and severe malnutrition may be going undetected--especially as it is the poorer, working mothers who find it most difficult to bring their children for weighing.

(ii) In district X, unlike district Y, mothers are discarding their colostrum, and feeding only sugar water to their babies in the first three days of life. This is no doubt contributing to perinatal mortality, both because it leads to undernourishment of the child, and because it weaks the child's immune resistance. It is not clear whether this is a practice followed by all the tribal groups in this area, or only the one visited.

Findings: The Supervision Process

Supervision visits to the periphery from the local referral centers are fairly regular, though understandably less frequent in the tribal areas where distances are great and transport systems poor.

The quality of supervision appears to be improving. Talks with field workers suggest that supervision visits are longer than previously, and that supervisors are spending time helping workers to solve local problems and giving on-the-spot training. This probably reflects the importance given to this in recent in-service training.

During discussion of the field visit findings with the managers who accompanied the mission in the field, it was noted that many of the most useful findings about health worker performance during the visit had come from talking to mothers in the villages, rather than from talking directly to workers. State and central program managers who had accompanied the mission stated that they themselves had learned a lot from these face to face meetings with service consumers.

Conclusions

Health service performance. The findings were discussed with both district and state level health and nutrition service managers. With the exception of the findings with regard to colostrum, their field experience was that the problems noted appeared to be widespread, and not limited to the areas visited. Three follow-up actions were agreed.

(i) Supervisors would take immediate steps to focus nutrition workers on the importance of increasing the percentages of children weighed. Progress will become a routine item for review at monthly staff meetings at referral centers.

(ii) The next round of in-service training is six months away. During the next three months, district supervisors and the district training teams throughout the state will be asked to ascertain whether the problems noted with health worker practice (poor targeting of outreach visits, inadequate attention to temporary contraceptive methods and nutrition education) are in fact widespread, as well as reporting on other problems in their areas. During the subsequent three months, curricula and trainer training will be reoriented so that special attention is paid during the next round of training to problems confirmed as widespread.

(iii) Managers noted that health practices in the tribal areas often differed substantially from other areas; and also practices differed substantially between the many different tribes. It was agreed that IEC strategies needed to be varied more to meet local tribes' needs. A study would be commissioned, with project funds, from the regional tribal research institute to identify differing health beliefs and behaviors, as a first step in refining and differentiating the IEC strategy.

Supervision process. It was agreed that in the next round of in-service training, it would be emphasized that supervisors should spend as much time on supervision visits with program clients as with program workers.

It was agreed that, after the next round of training, part of the time at each monthly management meeting at both district and state levels would be spent discussing supervisors' feedback from program clients. This would both directly help to ground management decisions in reality, and send signals to field supervisors that direct interaction with clients is important to management.

Policy Research Working Paper Series

| | Title | Author | Date | Contact for paper |
|---|---|---|---|---|
| WPS771 | Macroeconomic Structure and Policy in Zimbabwe: Analysis and Empirical Model (1965-88) | Ibrahim A. Elbadawi<br>Klaus Schmidt-Hebbel | September 1991 | S. Jonnakuty<br>39074 |
| WPS772 | Macroeconomic Adjustment to Oil Shocks and Fiscal Reform: Simulations for Zimbabwe, 1988-95 | Ibrahim A. Elbadawi<br>Klaus Schmidt-Hebbel | September 1991 | S. Jonnakuty<br>39074 |
| WPS773 | Are Ghana's Roads Paying Their Way? Assessing Road Use Cost and User Charges in Ghana | Reuben Gronau | September 1991 | J. Francis<br>35205 |
| WPS774 | Agricultural Pricing Systems and Transportation Policy in Africa | Mark Gersovitz | October 1991 | B. Gregory<br>33744 |
| WPS775 | The Macroeconomics of Public Sector Deficits: A Synthesis | William Easterly<br>Klaus Schmidt-Hebbel | October 1991 | R. Martin<br>39065 |
| WPS776 | Enforcement of Canadian "Unfair" Trade Laws: The Case for Competition Policies as an Antidote for Protection | Mark A. Dutz | October 1991 | N. Artis<br>37947 |
| WPS777 | Do the Benefits of Fixed Exchange Rates Outweigh Their Costs? The Franc Zone in Africa | Shantayanan Devarajan<br>Dani Rodrik | October 1991 | A. Bhalla<br>37699 |
| WPS778 | A Dynamic Bargaining Model of Sovereign Debt | Eduardo Fernandez-Arias | October 1991 | S. King-Watson<br>31047 |
| WPS779 | Special Programme of Research, Development and Research Training in Human Reproduction | Janet Nassim | October 1991 | O. Nadora<br>31019 |
| WPS780 | Optimal User Charges and Cost Recovery for Roads in Developing Countries | Ian G. Heggie<br>Vincy Fon | October 1991 | P. Cook<br>33462 |
| WPS781 | The Korean Consumer Electronics Industry: Reaction to Antidumping Actions | Taeho Bark | October 1991 | N. Artis<br>37947 |
| WPS782 | The Economic Effects of Widespread Application of Antidumping Duties to Import Pricing | Patrick Conway<br>Sumana Dhar | October 1991 | N. Artis<br>37947 |
| WPS783 | The Origins and Evolution of Antidumping Regulation | J. Michael Finger | October 1991 | N. Artis<br>37947 |
| WPS784 | Chemicals from Poland: A Tempest in a Teacup | Andrzej Olechowski | October 1991 | N. Artis<br>37947 |

Policy Research Working Paper Series

| | Title | Author | Date | Contact for paper |
|---|---|---|---|---|
| WPS785 | How Did the Asian Countries Avoid the Debt Crisis? | Ishrat Husain | October 1991 | S. King-Watson 31047 |
| WPS786 | Fiscal Policy for Managing Indonesia's Environment | Sadiq Ahmed | October 1991 | B. Prasertwaree 82477 |
| WPS787 | Private Investment Under Macroeconomic Adjustment in Morocco | Klaus Schmidt-Hebbel Tobias Muller | October 1991 | S. Jonnakuty 39074 |
| WPS788 | How Expectations Affect Reform Dynamics in Developing Countries | Francesco Daveri | October 1991 | S. Jonnakuty 39074 |
| WPS789 | Intrahousehold Inequality and the Theory of Targeting | Lawrence Haddad Ravi Kanbur | October 1991 | J. Sweeney 31021 |
| WPS790 | Reforming and Privatizing Hungary's Road Haulage | Esra Bennathan Jeffrey Gutman Louis Thompson | October 1991 | B. Gregory 33744 |
| WPS791 | Measuring Real Exchange Rate Instability in Developing Countries: Empirical Evidence and Implications | Lant Pritchett | October 1991 | K. Cabana 37947 |
| WPS792 | Reducing Labor Redundancy in State-Owned Enterprises | Jan Svejnar Katherine Terrell | October 1991 | B. Gregory 33744 |
| WPS793 | Decollectivization and the Agricultural Transition in Eastern and Central Europe | Karen M. Brooks | October 1991 | C. Spooner 30464 |
| WPS794 | How Do National Policies Affect Long-Run Growth? A Research Agenda | William Easterly Robert King Ross Levine Sergio Rebelo | October 1991 | R. Martin 39065 |
| WPS795 | Economic Stagnation, Fixed Factors, and Policy Thresholds | William Easterly | October 1991 | R. Martin 39065 |
| WPS796 | Excess Liquidity and Monetary Overhangs | Gerard Caprio, Jr. Patrick Honohan | October 1991 | W. Pitayatorakarn 37666 |
| WPS797 | Using Field Visits to Improve the Quality of Family Planning, Health, and Nutrition Programs: A Supervisor's Manual | Richard Heaver | October 1991 | O. Nadora 31091 |